Personality Disorders and Substance Abuse

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I. Scope of the Problem

II. Complex Diagnostic Issues

III. Treatment Implications

CRITERIA FOR PERSONALITY DISORDERS

A: *enduring problems with cognition, affectivity, interpersonal functioning, or impulsivity (at least 2)*

B: *inflexible and pervasive pattern across situations*

C: *significant distress or social/occupational impairment*

D: *early onset and persistent*

E: *not accounted for by another mental disorder*

F: *not due to a substance or medical condition*

DSM-IV PERSONALITY DISORDERS

Cluster A

Paranoid, Schizoid, Schizotypal

Cluster B

Antisocial, Borderline, Histrionic, Narcissistic

Cluster C

Avoidant, Dependent, Obsessive-Compulsive

BACKGROUND

- High personality disorder - addiction comorbidity
- Challenge most treatment settings and providers
- Poor response to traditional substance abuse treatment?
- More sensitive to relapse triggers?

PERSONALITY DISORDER COMORBIDITY FINDINGS

Depending on the study, **50-100%** of substance abusers have personality disorder

- **Opiates** (median=**79%**)
- **Cocaine** (median=**70%**)
- **Alcohol** (median=**44%**)

Verheul et al. (1995, 1998)

PERSONALITY DISORDER COMORBIDITY FINDINGS

- Personality disordered drug abusers average 4 disorders (2 for alcohol dependent)
- **Borderline** (10-25%) and **Antisocial** (20-45%) Personality Disorder are the most common
- Variability related to drug used, setting, assessment method, diagnostic system

DeJong et al. (1993)

Verheul et al. (1998)

PROBLEMS WITH DIAGNOSING PERSONALITY DISORDERS in Substance Abusers

- **Differentiation from Cluster B disorders**
- **Requires patients with:**
  - ***introspectiveness***
  - ***cognitive competence***
  - ***motivation to make dispositional attributions***
  - ***acknowledge rather than deny or project***
- **Hard to untangle two disorders with early onset and chronic course**

What Should be Excluded as a Personality Disorder Symptom?

- Behaviors when intoxicated or withdrawing
- Behaviors only engaged in when seeking substances or concealing use
- Behaviors that began after substance onset and are inconsistent with prior personality
- Behaviors that cease after a couple months of abstinence

UNTANGLING ADDICTION FROM PERSONALITY DISORDER

- Item-by-Item approach
  - before use or during sustained abstinence
  - pervasiveness, persistence, maladaptivity
- Obtaining non-substance related examples
- Not intoxicated or in acute withdrawal
- Time frame of at least past 2 years
- Don’t rely solely on self-report instruments
- Differentiate from other Axis I

Why Bother Untangling Addiction from Personality Disorder?

- Improve reliability and validity of diagnoses of both disorders
- Better understanding of the etiology and prognosis of both disorders
- Comorbidity informs treatment planning and service delivery systems
  - ***Who needs longer, more intensive treatment to achieve maximal symptom resolution?***

Why is it Important to Address Personality Disorder in Addiction Treatment?

- Match clients to different therapeutic modalities or services
- Increase treatment effectiveness and reduce early drop-out
- Enhance therapeutic alliance through sensitive discussion and acceptance of personality problems

TREATMENT IMPLICATIONS

- Unlike Axis I Clinical Disorders, the Axis II Personality Disorders have not received much attention
- Legacy of psychoanalysis and irrelevance to addiction
- Promising cognitive-behavioral therapies developed
- Promising targeted pharmacotherapies tested (neuroleptics for Cluster A; SSRIs for Cluster B; buspirone for Cluster C)

TREATMENT OUTCOMES

- Cluster B disorders more likely to drop-out early from inpatient and outpatient treatment
- Cluster C gender differences: males do worse, females do better than non-Cluster C counterparts
- Borderline Personality Disorder is more severe, but do just as well as non-BPD when provided psychiatrically enhanced inpatient
- ASPD and BPD are very heterogeneous diagnoses especially in substance abusers

ASPD TREATMENT OUTCOMES

- Inconsistent outcome predictor and no worse than other severe psychiatric disorders in terms of outcomes
- Poor outcomes accounted for by higher initial severity
- Those with comorbid major depression benefit as much as non-ASPD when provided individual therapy
- Structured coping skills may be better than interactional group therapy
- Do as well as non-ASPD when provided potent behavioral incentives
- Ability to form a positive therapeutic alliance important

Why Not Treat One Problem at a Time?

- **Addiction without Personality Disorder**
  - PD symptoms persist as major relapse vulnerabilities
  - PD impacts on others necessary for social support
  - PD part of the lifestyle that must change
- **PD without Addiction**
  - Substance use reduces retention, motivation, and stability necessary for change

What Makes Personality Disordered Substance Abusers Difficult?

- Precipitate more stressful life events through disagreeable or provocative behaviors thereby diminishing social support
- Struggle with issues of compliance and collaboration necessary for effective treatment
- Rapid change often a bad sign (slow is better)
- Impulsive, attention seeking, manipulative, or dangerous acting-out (self or other) potential
- Emotional volatility often higher
- Grandiosity, egocentricity, and indifference to others' needs are often high

What Makes Personality Disordered Substance Abusers Difficult?

- Interpersonal pathology re-enacted in-session
- Movement between extremes of dependence-avoidance continuum (interpersonal ambivalence)
- Movement between overidealizing and devaluing therapist and between over-confidence and over-hopelessness about recovery
- Attempts to win over (i.e., defeat) therapist
- View provider as extension of legal system
- Challenge the therapist boundary between personal commitment and professional distance

Guidelines for Managing PD in Early Phase of Addiction Treatment

- Empathic understanding of adaptive and maladaptive personality traits/symptoms
- Supportive limit setting
- Working with, not against, personality
- Not confronting until therapeutic alliance is firmly established
- Validate the person; challenge to behavior